Supreme Court, U.S.
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No. 06-614

IN THE

# Supreme Court of the United States

ERIC RUBIN-SCHNEIDERMAN,

*Petitioner*,

—against—

MERIT BEHAVIORAL CARE CORPORATION, SATI AHLUWALIA, M.D. and EMPIRE BLUE CROSS AND BLUE SHIELD,

*Respondents*.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

## PETITION FOR WRIT OF CERTIORARI

WHITNEY NORTH SEYMOUR, JR.
*Counsel of Record*
425 Lexington Avenue, Room 1721
New York, New York 10017
(212) 455-7640

*Attorney for Petitioner*

GABRIEL NORTH SEYMOUR,
*Of Counsel*

## Questions Presented for Review

This is a respectful request to the Justices of this Court to correct the 5-4 majority opinion in *Mertens v. Hewitt*, 508 U.S. 248 (1993) which is now in direct conflict with the Court's decision in *Aetna v. Davila*, 542 U.S. 200 (2004), prohibiting actions at law for injuries under ERISA.

1. Does Justice Story's 1836 treatise on Equity Jurisprudence show that the 5-4 majority opinion in *Mertens v. Hewitt*, 508 U.S. 248 (1993) omitted a key exception to the unavailability of monetary damages as an equitable remedy – the absence of "an adequate remedy at law"?

2. Does this court's subsequent 2004 decision in *Aetna v. Davila*, 542 U.S. 200 (2004), trigger that key exception by barring any adequate legal remedy under ERISA for injured beneficiaries?

3. As interpreted by *Mertens*, does ERISA allow health insurers to take "fraudulent advantage of the injured party" – in Justice Story's words – through bad faith denials of medically necessary care, and should *Mertens* now be modified and the judgment below be reversed to allow plaintiff to seek monetary damages against respondents?

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## OPINIONS BELOW

The full text of the Second Circuit order and opinion is set forth in the Appendix at page A-2.

Citations to official and unofficial reports of the opinions and orders entered in this case by Courts are as follows:

2006 WL 2381776 (C.A. 2 (N.Y.))
2005 WL 2249750 (S.D.N.Y.)
121 Fed. Appx. 414, 2005 WL 229862
(C.A.2 (N.Y.))
2003 WL 22019833 (S.D.N.Y.)
60 Fed. Appx. 887, 2003 WL 1913131
(C.A.2 (N.Y.))
2001 WL 1415165 (S.D.N.Y.)
163 F. Supp. 2d 227 (S.D.N.Y., 2001)

## JURISDICTION

The order and judgment of the Court of Appeals was entered on August 14, 2006. Jurisdiction to review the order and judgment in question is conferred by 28 U.S.C. § 1254(1)

## STATUTE INVOLVED

### 29 USC § 1132 (ERISA § 502(a)(3))

**§ 1132. Civil enforcement**

**(a) Persons empowered to bring a civil action**

A civil action may be brought -- ***

(3) by a participant, beneficiary or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

## STATEMENT OF THE CASE

This petition is based on (1) Justice Joseph Story's explanation of compensatory damages in courts of equity; (2) the plain conflict between this Court's *Mertens* and *Davila* decisions; and (3) powerful pleas for a more just and common sense interpretation of ERISA Section 502(a)(3) from scholars and Circuit Judges.

During the time of the divided bench, Courts of Equity awarded compensatory damages *when an adequate remedy was not available in courts of law* – as is now the case under ERISA. The members of the Court are respectfully urged to correct this erroneous omission in *Mertens* now and not wait until after years of needless hardship on working people and their families who depend on employee health benefit plans to provide adequate and competent health care.

### About this Case

Subject matter jurisdiction in the District Court was based on 28 U.S.C. Sec. 1331. Appellate jurisdiction in the Court of Appeals was based on 28 U.S.C. Sec. 1291.

This litigation is a battle-scarred veteran of the long judicial search for an ERISA remedy to permit

beneficiaries to seek compensatory damages against employee health plan administrators who improperly overrule treating physicians in the provision of patient care. Over the past six years, plaintiff's counsel have attempted to follow various well-intended judicial efforts to find a way to protect group health plan beneficiaries – as Congress said it intended when it enacted ERISA – a goal that the Supreme Court has so far prevented. This is plaintiff's third appeal from dismissal of his claim in the District Court, all attempting to follow the changing judicial interpretations of ERISA.

Fortunately, this plaintiff reserved the right throughout the litigation to seek damages as an "appropriate equitable remedy" under ERISA Section 502(a)(3) and it is that issue that is now the present engine that drives this case.

Following this Court's 2004 decision in *Aetna v. Davila*, plaintiff filed a Second Amended Complaint in the Southern District of New York detailing his claim of breach of fiduciary duty against defendants and seeking monetary damages under 502(a)(3). The District Judge who had previously approved a similar remedy in a case involving different facts under the same section of ERISA, but was later reversed by the Second Circuit, felt bound to dismiss Eric Rubin-Schneiderman's complaint as a matter of law. The Court of Appeals impliedly suggested that this plaintiff seek leave to present the question to this Court.

Petitioner urges the Justices to re-address the erroneous 5-4 holding in *Mertens v. Hewitt*, 508 U.S. 248 (1993). Such action is supported by the history of damages in courts of equity and by a groundswell of judicial and scholarly outcry against the majority ruling in *Mertens*, not only by the four original dissenters (Justices White,

Rehnquist, Stevens and O'Connor), but also by such respected judicial voices as Judges Calabresi (2nd Circuit) and Becker (3rd Circuit) and most recently by Justices Ginsburg and Breyer in *Davila*, as well as the country's leading ERISA scholar, John H. Langbein of Yale Law School. [Langbein, What ERISA Means by 'Equitable': The Supreme Court's Trail of Error in *Russell, Mertens* and *Great-West*, 103 Columbia L. Rev. 1317 (2003)]

**The Facts**

At the time this action first arose, plaintiff was a young man suffering from a debilitating psychiatric illness that caused dangerously self-destructive thoughts and behavior. When he sought admission to an in-patient mental health care facility, the insurance company's mental health care manager misdiagnosed the severity of his condition and recommended an inappropriate out-patient course of treatment – a decision that eventually led to plaintiff's attempted suicide.

Defendants are Empire Blue Cross and Blue Shield, the administrator of plaintiff's health plan; Merit Behavioral Care Corporation, the mental health care manager for plaintiff's plan; and Dr. Sati Ahluwalia, a physician employee of Merit. It was Dr. Ahluwalia who made the erroneous determination that plaintiff's condition was treatable by out-patient therapy, rather than the more expensive in-patient treatment recommended by plaintiff's personal psychiatrist and approved by the admitting physician at the in-patient institution.

Dr. Ahluwalia's medical treatment recommendation was made during pre-treatment "utilization review" performed by Merit Behavioral Care Corporation ("MBC")

as agent for defendant Empire Blue Cross and Blue Shield ("EBCBS"), plaintiff's group health insurer.[1]

Plaintiff's health plan was Empire's "Blue Choice PPO" contract. That plan provides that while Empire was the administrator for all benefits except mental health and behavioral care, Merit performed the functions of plan administrator on Empire's behalf for the plan's mental health and behavioral care benefits, and was therefore an ERISA fiduciary. The plan provisions specify that a beneficiary cannot receive mental health and behavioral care benefits without Merit's advance approval. Merit's health care responsibility is described in the plan documents as follows:

> Your BlueChoice PPO benefits also include a behavioral health care management program. Like our Utilization Management Program, this program is designed to provide you with the highest quality of mental health and substance abuse care in the most appropriate setting.
>
> (A - 17) (Emphasis added.)

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[1] New York Ins. Law Sec. 4900 and Public Health Law Sec. 4900 define "utilization review" as:

> The review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary. (Emphasis added.)

**Detailed Allegations in the Complaint**

In August, 1997, plaintiff's treating psychiatrist, Dr. Samuel C. Klagsbrun, determined that plaintiff should be admitted to Four Winds Hospital, an in-patient psychiatric facility in Katonah, New York. On September 5, 1997, plaintiff's father, David Schneiderman, spoke by telephone with Merit's Mental & Nervous Disorders Inpatient Division. He was informed that Merit's pre-approval of plaintiff's inpatient treatment at Four Winds Hospital was required in order to receive coverage under the BlueChoice PPO contract and that plaintiff was required to undergo a pre-admission psychiatric evaluation.

On September 8, 1997, plaintiff underwent a pre-admission psychiatric evaluation at Four Winds Hospital. On the same day, plaintiff applied to defendant Merit for preauthorization approving his admission to Four Winds Hospital and his inpatient treatment at that facility. The application process consisted primarily of telephone conversations between Merit employees and the Four Winds evaluating physician.

Despite plaintiff's acute psychiatric condition and the recommendation of his treating physician and of Dr. Jose Freire, the evaluating physician at Four Winds, Merit medical personnel verbally denied plaintiff's application for admission to Four Winds Hospital over the telephone.

In a follow-up letter to plaintiff dated September 9, 1997, Merit physician-advisor Sata Ahluwalia, M.D. stated that "Merit Behavioral Care determines the medical necessity of mental health and substance abuse treatment to beneficiaries of Blue Cross and Blue Shield," and then stated that "MBC cannot authorize inpatient psychiatric treatment at Four Winds Hospital" because "[b]ased on

information given, the current level of symptoms can be treated at a lower level of care. Recommendation is for an intensive outpatient program." No reason was given, only the result.

At no time did Dr. Ahluwalia or any other Merit or Empire physician or employee examine or evaluate plaintiff in person prior to determining that inpatient treatment was purportedly not medically necessary to treat plaintiff's psychiatric disorder.

At no time did Dr. Ahluwalia or any other Merit or Empire physician or employee interview plaintiff, even telephonically, prior to determining that inpatient treatment was purportedly not medically necessary to treat his psychiatric disorder.

Plaintiff's complaint alleges upon information and belief, that at no time did Dr. Alhuwalia or any other Merit or Empire physician or other employee examine plaintiff's medical and psychiatric records prior to determining that inpatient medical treatment was purportedly not medically necessary for treating his psychiatric disorder.

Subsequent events proved that, contrary to Merit's utilization review determination, the treating physician's recommendation of inpatient treatment for plaintiff at Four Winds Hospital was medically necessary and essential for the proper treatment of plaintiff's psychiatric disorder.

On April 6, 1998, plaintiff attempted to commit suicide by ingesting a large overdose of pills and medications. He was fortuitously discovered at the brink of death by his father who had him rushed to St. Luke's-Roosevelt Hospital where plaintiff received critical care for several hours in the Emergency Room. Medical personnel

intubated plaintiff and put him on life support. After receiving life-saving medical treatment, plaintiff was transferred to the Intensive Care Unit. Three days later, on April 9, 1998, he was transferred by ambulance to Four Winds Hospital for in-patient treatment in an extremely despondent mental state. As a result of this episode, plaintiff alleges that he has suffered permanent injury to his mental health and future well-being.

**Procedural History**

Plaintiff originally commenced this action on September 29, 2000 by filing a complaint in New York State Supreme Court. The Complaint alleged negligence on behalf of Merit and Ahluwalia and negligent hiring and supervision on the part of Merit and Empire. By Notice of Removal dated October 23, 2000, all three defendants removed the action to the United States District Court.

Plaintiff filed a timely motion to remand the case to New York State Supreme Court. By opinion and order dated April 9, 2001, the District Court (Martin, J.) denied plaintiff's remand motion, finding that plaintiff's claims based on negligent refusal to authorize treatment were subject to federal jurisdiction under the doctrine of complete preemption and that the remaining claims for negligent hiring and supervision were subject to the Court's supplementary jurisdiction.

Thereafter, plaintiff filed his first Amended Complaint realleging his state law claims, and adding additional ERISA claims.

Defendants moved to dismiss the Amended Complaint, and by Opinion and Order dated November 13, 2001, the District Court granted defendants' motion to

dismiss. The District Court found that plaintiff's state law claims were preempted by the ERISA statute and that the ERISA causes of action failed to state a claim for which relief could be granted.

Plaintiff's first appeal from the two District Court decisions resulted in a summary Order in the Court of Appeals vacating the judgment of dismissal and remanding the case for reconsideration in light of its recent *Cicio* decision. That order was filed April 18, 2003. The District Court then invited motions from the parties. Plaintiff renewed his motion to remand; Dr. Ahluwalia renewed her motion to dismiss; and Empire filed a motion for summary judgment.

On August 27, 2003, the District Court (Martin, J.) filed an Opinion and Order adhering to its earlier dismissal. A final judgment of dismissal was filed on October 27, 2003. Plaintiff appealed once again to the Court of Appeals. While that appeal was pending, the Supreme Court filed its decision in *Aetna v. Davila*, 542 U.S. 200 (2004), which addressed the same core issues then pending in this case, and holding that all claims for injuries were preempted by ERISA.

The Court of Appeals then remanded the case once again, this time to permit plaintiff to request leave to file a Second Amended Complaint seeking recovery under ERISA § 502(a)(3) for breach of fiduciary duty in light of the concurring opinion of Justices Ginsburg and Breyer in the *Aetna* case. The defendants stipulated to the filing of the new complaint and the defendants then moved to dismiss the Second Amended Complaint under Rule 12(b)(6) for failure to state a claim.

Following oral argument on October 11, 2005, District Judge Alvin K. Hellerstein granted the motions to dismiss, stating his principle reasons as follows:

> Mr. Seymour, [with] the same regret I reflected in my decision in *Gerosa v. Savasta*, I reluctantly grant the motion by the defendants to dismiss the complaint under Rule 12(b)(6) of the Federal Rules of Civil Procedure for failure to state a claim for relief.
>
> It is clear to me that the claim of Mr. Rubin-Schneiderman is for damages not equitable relief.***
>
> The allegation is that while in outpatient treatment, the plaintiff attempted suicide, and fortunately it was only an attempt, but the plaintiff claims injury and sues for damages.***
>
> Under Section 502(a)(3)B, the law provides that a civil action may be brought by participant beneficiary or fiduciary to obtain other appropriate equitable relief. The Supreme Court has held and the Second Circuit has held you cannot disguise a claim for damages by labeling it as a claim for equitable relief.***
>
> Mr. Seymour, I wish you well in your move up to the Second Circuit again, and I would like to see a change in the law and a liberalization of it but I think my hands are tied.
>
> (A–555-559)

## ARGUMENT

## WHY CERTIORARI SHOULD BE GRANTED

### POINT I

### JUSTICE JOSEPH STORY'S 1836 TREATISE ON EQUITABLE JURISPRUDENCE SHOWS THAT THE 1993 5-4 MAJORITY OPINION IN *MERTENS V. HEWITT* MISCONSTRUED THE PURPORTED UNAVAILABILITY OF COMPENSATORY DAMAGES AS AN EQUITABE REMEDY AGAINST FIDUCIARIES DURING THE TIME OF THE DIVIDED BENCH

Associate Justice Story's Commentaries on Equity Jurisprudence as Administered in England and America, first published in 1836, was a major reference and teaching tool through fourteen editions, the last appearing in 1918, more than 60 years after his death.

In Equity Jurisprudence, Story devotes an entire chapter to "Compensation and Damages" (Ch. XIX at pages 104-109). The chapter begins with the generality used as the premise for the majority opinion in *Mertens*, that monetary damages were usually left to courts of law, but then goes on to qualify that generality by an important exception that was overlooked in the majority opinion in *Mertens* – and requires the opposite outcome in the context of ERISA's Section 502(a)(3) remedies:

> It may be stated, as a general proposition, that, for breaches of contract and other wrongs and injuries, cognizable at law, Courts of Equity do not entertain jurisdiction to give redress by way of compensation or damages, where these constitute the sole object

> of the bill. For, wherever the matter of the bill is merely for damages, there the remedy is properly at law, and can be better ascertained by a Jury, than by the conscience of the Chancellor. And, indeed, the just foundation of equitable jurisdiction fails in all such cases, as there is a plain, complete, and adequate remedy at law. Compensation or damages (it should seem) ought to be decreed in Equity only as incidental to other relief asked, and usually given; or, where there is no adequate remedy at law.
>
> Story, Equity Jurisprudence, 104-5 (1st ed., 1836) (emphasis added) (citing English, Federal and State cases as authority.)[2]

There is no adequate remedy at law under ERISA, as the history of the present case so clearly demonstrates (see Procedural History, *supra*), and as this Court has now squarely so held in *Aetna v. Davila*, 542 U.S. 200 (2004).

The *Davila* denial of any adequate remedy at law for beneficiaries of employee health care plans for breach of statutory and professional fiduciary duties by administrators activates the exception to the general equity denial of damages – to wit, "...where there is no adequate remedy at law."

Justice Story explained the reason behind this exception in Section 798 of his Equity Jurisprudence, *supra*, pages 107-108), stating:

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[2] Justice Story's lengthy footnote includes the following statement:

> Though plaintiff has a remedy at law, this will not oust jurisdiction. It must be plain and adequate, and as certain, prompt, complete, and efficient to attain the ends of justice and its prompt administration as the remedy in equity. (citing four American cases) (fn.1, page 474)

> [W]here no ... remedy lies at law, there a peculiar ground for the interference of Courts of Equity exists, to prevent irreparable mischief, or to avoid a fraudulent advantage being take of the injured party.[3]

Preventing a "fraudulent advantage being taken of the injured party" is exactly what is at issue under ERISA today, as set forth in greater detail in Point III. As will be seen, the time is now here for this court to vacate the majority opinion in *Mertens* as promptly and decisively as possible.

## POINT II

## *AETNA v. DAVILA* FIRMLY CLOSED THE DOOR ON LEGAL REMEDIES FOR INJURED ERISA BENEFICIARIES, AND SIMULTANEOUSLY PROVIDED THE BASIS FOR OPENING THE DOOR TO EQUITABLE COMPENSATORY DAMAGES

On June 21, 2004, a unanimous Court handed down its decision the the consolidated cases of *Aetna Health Inc. v. Juan Davila* and *Cigna Healthcare of Texas, Inc. v. Ruby R. Calad, etal*, 542 U.S. 200 (2004). The decision marked a major milestone in ERISA health benefit litigation: (1) it established without any equivocation or room for doubt that no common law remedies are available for ERISA beneficiary claims for injuries against plan administrators; and (2) that medical necessity health care decisions by physicians employed by plan administrators are fiduciary

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[3] A lengthy footnote cites a number of English and American authorities, including a decision of this Court in *Pratt v. Law*, 9 Cranch, 493, 494.

decisions, not "treatment" decisions.

Those unanimous rulings directly contradict the very premise of the majority opinion in *Mertens* that equitable remedies under § 502(a)(3) cannot include monetary damages. They trigger Justice Story's exception, and therefore require reversal of the judgment below in this case.

**No Adequate Remedy at Law**

The key language in *Aetna v. Davila* prohibiting any legal remedy for beneficiary injuries under ERISA appears on pages 208 and 209 of the Court's opinion:

> ERISA's "comprehensive legislative scheme" includes "an integrated system of procedures for enforcement." *Russell*, 473 U.S., at 147 (internal quotation marks and citation omitted). This integrated enforcement mechanism, ERISA § 502(a), 29 U.S.C. § 1132(a), is a distinctive feature of ERISA, and essential to accomplish Congress' purpose of creating a comprehensive statute for the regulation of employee benefit plans.
>
> * * *
>
> Therefore, any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.
>
> * * *
>
> Thus, the ERISA civil enforcement mechanism is one of those provisions with such "extraordinary pre-emptive power" that it "converts an ordinary

> state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule."

**Medical Necessity Determinations Are Fiduciary Decisions**

The Court's other major ruling in *Aetna v. Davila* was that medical necessity determinations that are made as part of an Administrator's review of health benefits are fiduciary decisions and are not independent treatment decisions, as many courts and others (including this plaintiff) had mistakenly interpreted *Pegram v. Herdrich* 530 U.S. 211 (2000).

> Hence, a benefit determination is part and parcel of the ordinary fiduciary responsibilities connected to the administration of a plan. See *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996) (relevant plan fiduciaries owe a "fiduciary duty with respect to the interpretation of plan documents and the payment of claims"). The fact that a benefits determination is infused with medical judgments does not alter this result.
>
> 542 U.S. 200, at 219

**Historically, Equity Has Required a Fiduciary Who Violates His Duties to "Repair All The Damages"**

The earliest known standard work on equity was Henry Ballow, A Treatise on Equity, published in London in 1737. Book V of that work (starting at page 117) deals exclusively with Damages. Section 1 begins as follows:

> Since a Man is bound in Equity, not only to perform his Engagements, but also to repair all the Damages

> that accrue naturally from the Breach of them: We ought not to omit treating of these .... As for Damages in general, the measure of them is to be taken from the Quality of the Action, the Cause, and the Event. For where there is any Fraud or knavish Dealing, the Sentence ought to have the utmost Extent that the Rigor of the Law can give it; because the Knavery implies a Will and Intention to do all the Hurt that is possible.

Quaint as these words sound today, in substance they fit exactly the plaintiff's claim against the fiduciary defendants in this case.

Ballow's successor, John Fonblanque, continued this same language in A Treatise on Equity, printed in 1795. The language was also reprinted in the American editions of Ballow's work. (*E.g.*, 3rd edition, printed in Philadelphia in 1805, at pp. 419-413.)

Likewise, the American writer, John Adams, in his The Doctrine of Equity: Being a Commentary on the Law as Administered in the Court of Chancery (Philadelphia, 1850), states (at page 93): "If a breach of trust has been committed, the trustee will be liable to make good any consequent loss, whether immediately resulting from it, or traceable as its effect."

Although these are pre-ERISA cases and deal primarily with fiduciary duties in handling financial matters, the equity "make-whole" doctrine [argued by the United States as *amicus* in *Aetna v. Davila*, see 542 U.S. 200 at 221, fn.7] plainly was a form of damages widely used by courts of equity during the time of the divided bench, and should be fully available to plaintiffs seeking an appropriate equitable remedy under § 502(a)(3).

## POINT III

## ERISA, AS PRESENTLY INTERPRETED BY THIS COURT, ALLOWS HEALTH INSURERS TO TAKE "FRAUDULENT ADVANTAGE OF THE INJURED PARTY" (JUSTICE STORY'S WORDS)

The practical effects of ERISA, as presently interpreted by *Mertens*, are discussed in Circuit Judge Becker's concurring opinion in *DiFelice v. Doe*, 346 F.3d 442, (3rd Cir., 2003), at pp. 453 *et seq*.

> ... ERISA generally and § 514(a) particularly, have become virtually impenetrable shields that insulate plan sponsors from any meaningful liability for negligent or malfeasant acts committed against plan beneficiaries in all too many cases. This has unfolded in a line of Supreme Court cases that have created a "regulatory vacuum" in which virtually all state law remedies are preempted but very few federal substitutes are provided.
>
> (*Id*., at 456)

Judge Becker provides a practical, common sense description of the negative results caused by denying equitable damages under ERISA:

> The unavailability of extra-contractual damages has effects that are perverse. First, as stated above, contingency fees are rendered entirely impractical – precious few lawyers would be willing to undertake a horrendously complex case of uncertain outcome when the greatest potential reward is merely provision of the care that had been contractually promised. Without contingency fees, participants in the midst of medical crises are completely at the

mercy of HMOs unless they are fortunate enough to have the financial means to bring a suit for an injunction, a circumstance which is no doubt exceptional. Although it might seem a simple matter to seek an injunction compelling contractually-guaranteed coverage of a procedure, nothing is further from the truth where – as with Mr. DiFelice – the contractual availability of coverage hinges on a highly fact-intensive determination of medical necessity involving accepted standards of care and tolerable levels of risk for the participant's malady. To the extent that participants are unable to seek an injunction compelling coverage, ERISA's remedial scheme is almost entirely illusory.

The second perverse effect is that, at the same time as ERISA makes it inordinately difficult to bring an injunction to enforce a participant's rights, it creates strong incentives for HMOs to deny claims in bad faith or otherwise "stiff" participants. ERISA preempts the state tort of bad-faith claim denial, *see Pilot Life*, 481 U.S. at 54-56, 107 S.Ct. 1549, so that if an HMO wrongly denies a participant's claim even in bad faith, the greatest cost it could face is being compelled to cover the procedure, the very cost it would have faced had it acted in good faith. Any rational HMO will recognize that if it acts in good faith, it will pay for far more procedures than if it acts otherwise, and punitive damages, which might otherwise guard against such profiteering, are no obstacle at all. Not only is there an incentive for an HMO to deny any particular claim, but to the extent that this practice becomes widespread, it creates a "race to the bottom" in which, all else

> being equal, the most profitable HMOs will be those that deny claims most frequently.
>
> In sum, ERISA's remedial scheme gives HMO's every incentive to act in their own and not in their beneficiaries best interest while simultaneously making it incredibly difficult for plan participants to pursue what meager remedies they possess, a confounding result for a statute whose original purpose was to protect employees.
>
> (*Id.*, at 459)

Like other judges concerned about the consequences of the *Mertens* majority opinion, Judge Becker has urged that either Congress or the Supreme Court act soon to correct the damage the decision has produced. Realistic observers of today's campaign finance abuses in Congress – and the huge sums that the health care industry has poured into Congressional incumbents' campaign coffers – are painfully aware that expecting remedial action from Congress in the foreseeable future is a pipe dream. If change is to come, it must be from the Supreme Court itself. The one sure way to speed up that change is to award compensatory damages to this plaintiff under § 502(a)(3).

Judge Becker's colleague, 3rd Circuit Judge Ambro, joined him in urging the Supreme Court to reverse and rewrite the *Mertens* decision:

> I join the chorus calling for a fresh look from higher authority to promote better the primary Congressional purpose of ERISA – protecting plan participants and their beneficiaries. (*Id.*, at 468)

In her concurring opinion in *Aetna v. Davila*, Justice Ginsburg (joined by Justice Breyer) urged resolution of the unjust and increasingly tangled judicial interpretations of ERISA by utilizing the relief available under Section 502(a)(3) in the remedial sense, by making the plaintiff whole for defendants' wrongdoing through a monetary award under traditional trust law.

This solution was explicitly proposed by the Government in its *amicus* brief filed on behalf of the Secretary of Labor in the *Aetna* case in the Supreme Court, and was endorsed by the two Associate Justices in their concurring opinion. (542 U.S. 200 at 222.)

The Supreme Court majority at the end of its opinion in *Aetna Health Care, Inc. v. Davila* also noted the potential applicability of "make whole" monetary equitable remedies to award relief, but declined to rule on the question until a proper case presented the issue squarely:

> The United States, as *amicus*, suggests that some individuals in respondents' positions could possibly receive some form of "make-whole" relief under ERISA §502(a)(3). Brief for United States as *Amicus Curiae* 27, n. 13. However, after their respective District Courts denied their motions for remand, respondents had the opportunity to amend their complaints to bring expressly a claim under ERISA §502(a). Respondents declined to do so; the District Courts therefore dismissed their complaints with prejudice. See App. 147-148; *id.*, at 298; App. B to Pet. for Cert. in No. 02-1845, pp. 34a-35a; App. B to Pet. for Cert. in No. 03-83, p. 40a. Respondents have thus chosen not to pursue any ERISA claim, including any claim arising under

> ERISA §502(a)(3). The scope of this provision, then, is not before us, and we do not address it.
>
> (542 U.S.200 at 221, fn.7.)

This action presents that issue squarely.

## CONCLUSION

*"Chancery is ordained to supply the Law, not to subvert the Law."* – Lord Bacon[4]

The judgment below should be reversed, *Mertens* should be revisited and corrected, and plaintiff should be allowed to seek compensatory damages under ERISA § 502(a)(3).

Respectfully submitted,

Whitney North Seymour, Jr.
425 Lexington Avenue,
Room 1721
New York, New York 10017
Tel: (212) 455-7640
FAX: (212) 455-7721
Email: wseymour@stblaw.com
Counsel of Record

Gabriel North Seymour
*Of Counsel*

October 31, 2006

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[4] From the title page of Joseph Story's Commentaries on Equity Jurisprudence (1st ed.,1836)

# APPENDIX

## APPENDIX


| | |
|---|---|
| JUDGMENT OF DISTRICT COURT | A-1 |
| ORDER AND JUDGMENT OF COURT OF APPEALS | A-2 |

**UNITED STATES DISTRICT COURT**
**SOUTHERN DISTRICT OF NEW YORK**

----------x

ERIC RUBIN-SCHNEIDERMAN,

Plaintiff,

-against-

MERIT BEHAVIORAL CARE CORP., M.D., SATI AHULWALIA, EMPIRE BLUE CROSS AND BLUE SHIELD,

Defendants.

----------x

00 **CIVIL** 8101 (AKH)

**JUDGMENT**

Whereas the above-captioned action having come before this Court, and the matter having come before the Honorable Alvin K. Hellerstein, United States District Judge, and the Court, on October 12, 2005, having rendered its Order granting defendant's motion to dismiss, it is,

**ORDERED, ADJUDGED AND DECREED:** That for the reasons stated in the Court's Order dated October 12, 2005, defendant's motion to dismiss is granted; accordingly, the case is closed.

Dated: New York, New York
October 18, 2005

J. MICHAEL McMAHON

BY: /s/
Deputy Clerk

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

**SUMMARY ORDER**

**THIS SUMMARY ORDER WILL NOT BE PUBLISHED IN THE FEDERAL REPORTER AND MAY NOT BE CITED AS PRECEDENTIAL AUTHORITY TO THIS OR ANY OTHER COURT, BUT MAY BE CALLED TO THE ATTENTION OF THIS OR ANY OTHER COURT IN A SUBSEQUENT STAGE OF THIS CASE, IN A RELATED CASE, OR IN ANY CASE FOR PURPOSES OF COLLATERAL ESTOPPEL OR RES JUDICATA.**

At a stated term of the United States Court of Appeals for the Second Circuit, held at the Thurgood Marshall United States Courthouse, Foley Square, in the City of New York, on the 14th day of August, two thousand and six.

PRESENT:

HON. ROBERT D. SACK
HON. ROBERT A. KATZMAN
Circuit Judges,
HON. J. GARVAN MURTHA*
District Judge.

- - - - - - - - - - - - - - - - - - - - - - -

ERIC RUBIN-SCHNEIDERMAN,
Plaintiff-Appellant, No. 05-5851

-v-

MERIT BEHAVIORAL CARE CORPORATION, EMPIRE BLUE CROSS and BLUE SHIELD,
Defendants-Appellees.

- - - - - - - - - - - - - - - - - - - - - - -

*Of the United States District Court for the District of Vermont, sitting by designation.

| | |
|---|---|
| Appearing for Appellant: | WHITNEY NORTH SEYMOUR, JR., NEW YORK, NY |
| Appearing for Appellees Merit Behavioral Care Corporation and Sati Ahluwalia: | JONATHAN K. COOPERMAN, Kelley, Drye & Warren (Jennifer A. Huber, of counsel, New York, NY |
| Appearing for Appellee Empire Blue Cross and Blue Shield: | DALY D.E. TEMCHINE, Epstein Becker & Greene, P.C., New York, NY. |

Appeal from the United States District Court for the Southern District of New York (Alvin K. Hellerstein, Judge).

UPON DUE CONSIDERATION, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the judgment be, and it hereby is, AFFIRMED.

The plaintiff, Eric Rubin-Schneiderman, brought suit against the defendants – Empire Blue Cross and Blue Shield ("Empire"), his health insurance company; Merit Behavioral Care Corporation ("Merit"), the company that performs utilization review of mental health services for Empire; and Sati Ahluwalia, an employee of Merit – under section 502(a)(3) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(3). He alleged that the defendants negligently failed to authorize his hospitalization in a psychiatric facility and that, as a result of this negligence, he suffered permanent injury from a failed suicide attempt. The district court granted the

defendants' motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) on the ground that, under recent Supreme Court precedents beginning with Mertens v. Hewitt Assocs., 508 U.S. 248 (1993), the monetary damages Rubin-Schneiderman sought were unavailable under ERISA § 502(a)(3). [SPA 3-6]

Rubin-Schneiderman's primary argument on appeal is that Mertens was wrongly decided and we should not follow it. But "[w]e cannot overrule the Supreme Court." Bach v. Pataki, 408 F.3d 75, 86 (2d Cir. 2005); see also Rodriguez de Quijas v. Shearson/Am. Express, Inc., 490 U.S. 477, 484 (1989); Cicio v. Does, 321 F.3d 83, 106-07 (2d Cir. 2003) (Calabresi, J., dissenting in part), vacated and remanded, 542 U.S. 933 (2004). Mertens and its progeny are binding on us and we are obligated to follow those decisions. See, e.g., Coan v. Kaufman, --- F.3d ----, 2006 WL 2075129, at *10, 2006 U.S. App. LEXIS 18444, at *33 (2d Cir. July 21, 2006).

Rubin-Schneideman also urges us to adopt Justice Ginsburg's suggestion in Aetna Health Inc. v. Davila, 542 U.S. 200 (2004), that monetary relief under section 502(a)(3) may be more widely available in suits against ERISA fiduciaries than against non-fiduciaries. See id. at 223-24 (Ginsburg, J., concurring). As we recently concluded, however, the fact that a defendant is a fiduciary does not change the requirement of section 502(a)(3) that the relief sought be "equitable." See Coan, 2006 WL2075129, at *11, 2006 U.S. App. LEXIS 18444, at 36-37; Sereboff v. Mid Atlantic Med. Servs., Inc., --- U.S. ---, 126 S.Ct. 1869, 1874 (2006). Because Rubin-Schneiderman is seeking compensatory monetary damages,

a legal remedy, he cannot proceed under ERISA § 502(a)(3).

For the foregoing reasons, the judgment of the District Court is hereby AFFIRMED.

FOR THE COURT:
ROSEANN B. MACKECHNIE, Clerk
/s/ Lucille Carr
By: